Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug, Please do so in the space provided and **FAX form back to the dispensing pharmacy**. Otherwise, continue with the Prior Authorization process by completing the rest of this form & FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka)	**Rx** _____ Physician signature _____ Date

Unless otherwise indicated, the chemical name includes branded products and all dosage forms.

ANTIEMETIC DRUGS - Serotonin 5HT3 Antagonists			
Preferred Drug Covered		**Non-preferred Prior Authorization Required**	
Ondansetron	Zofran® Zofran ODT®	Dolasetron	Anzemet®
		Granisetron, Oral & Inj	Kytril®
		Non-preferred	
		Granisetron, Topical	Sancuso®

** **Indicates REQUIRED information**

****CONSUMER NAME:** _____ ****Medicaid Number:**_____

****PHARMACY** Name**:**_____ ****Phone #:**_____ **Fax #:_____

** Medicaid #:_____ **NPI #:_____ ****NDC:**_____

** ***Indicate:*** Non-Preferred Drug prescribed: _____ Other:_____

****PRESCRIBER** Name**:**_____ ****Phone #:**_____ **Fax #:_____

****Medicaid #:**_____ NPI #:_____

** ***Indicate:*** Preferred Drug tried: _____ Length of trial: _____

** ***Check:*** the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

☐ Medical intolerance to Preferred Drug. **Provide clinical symptoms**:_____

_____

☐ Inadequate response to Preferred Drug.

☐ Absence of appropriate formulation or indication of the drug. Please specify:_____

_____

****Prescribing Physician's signature:** _____**Date:** _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593.

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